

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b> c. LENGTH OF STAY IN ID <b>Lifetime</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>DQA McCready Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b> d. STREET ADDRESS <b>Peyton Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>GROVER</b> Middle <b>CLEVELAND</b> Last <b>ADAMS, JR.</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>24</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 28, 1922</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerical</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Post Office &amp; Retail</b>	
11. BIRTHPLACE (State or foreign country) <b>Crisfield, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Grover C. Adams, Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Marie Bethard</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes give war or dates of service) <b>WW II</b>		16. SOCIAL SECURITY NO. <b>218-10-8055</b>	
17. INFORMANT <b>Mrs. Zella B. Adams, same as 2. a, b, c, d above</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction complicated and related to severe uncontrolled chronic anxiety state.</b> DUE TO (b) <b>anxiety state.</b> DUE TO (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) <b></b>			INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b></b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HDW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b></b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>	20f. (City or town) (County) (State) <b></b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>C. G. Rawley</b>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>C. G. Rawley, M.D.</b>		22. DATE SIGNED <b>12/28/67</b> Address (Street, city, town, or county) <b>Crisfield, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12/27/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Sunnyridge Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Crisfield Md.</b>
24. FUNERAL DIRECTOR <b>Levin R. Wilson, Princess Anne, Md.</b>		25a. REC'D BY REGISTRAR <b>JAN 2 1968</b> 25b. REGISTRAR'S SIGNATURE <b>James Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b> c. LENGTH OF STAY IN 1b <b>40</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>McCready Memorial Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b> d. STREET ADDRESS <b>Apt. 31, Somers Cove</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Marvin</b> Middle <b>Banks</b> Last <b>Banks</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>16</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 31, 1909</b>
9. AGE (In years last birthday) <b>58</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Crisfield Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>JAMES BANKS</b>		14. MOTHER'S MAIDEN NAME <b>Lucy Coulbourne</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>215-18-4723</b>	
17. INFORMANT <b>Ellie Banks</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>The Myocarditis</b> DUE TO <b>Branchopneumonia</b> DUE TO <b>Rhabdomyosarcoma</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Mar. 2, 1967</b> to <b>Dec 16, 1967</b> , that (I) (we) last saw the deceased alive on <b>12/16/67</b> 19__, and that death occurred <b>6:15</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>A. N. Barr, M.D.</b>		22b. DATE SIGNED <b>12/23/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>A. N. Barr, M.D.</b>		22d. ADDRESS <b>Crisfield, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>12/20/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Asbury</b>	23d. LOCATION (City or town) (County) (State) <b>Crisfield Md.</b>
24. FUNERAL DIRECTOR <b>Anthony E. Ward Crisfield Md.</b>		25a. REC'D BY REGISTRAR <b>JAN 2 1968</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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FOR STATE  
HEALTH DEPT.

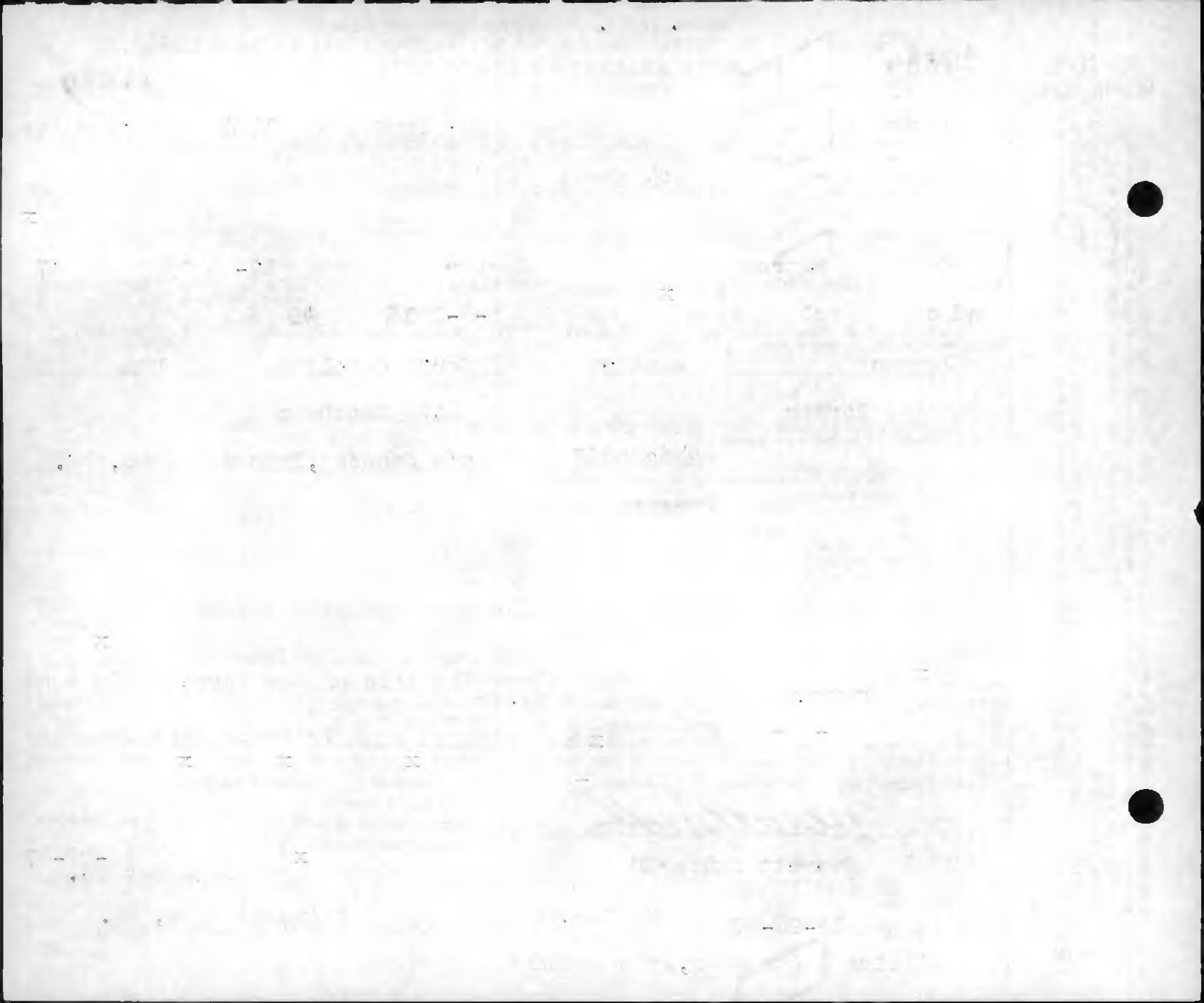
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
SM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Princess Anne</b> c. LENGTH OF STAY IN ID <b>24 hours</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>New York City</b> b. COUNTY <b>1787 Amsterdam Ave</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>6813</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Monroe</b> First Middle Last <b>Carter</b>		4. DATE OF DEATH Month Day Year <b>12- 25 19 67</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>col</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-8-1918</b> 9. AGE (in years last birthday) <b>49 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Forman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Factory</b>	
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles Carter</b>		14. MOTHER'S MAIDEN NAME <b>Etta Matthews</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes give war or dates of service)</b>		16. SOCIAL SECURITY NO. <b>246260068</b>	
17. INFORMANT <b>Lizzie Johnson, Princess Anne, Md.</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Drowning</b> <b>929.8</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DUE TO</b> (c) <b>DUE TO</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>acute Alcoholism</b>		INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>Drowning</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>body found along the side of the Perryhawkin road</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>12-25-67</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> <b>West Postoffice Road Princess Anne Somerset Md</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <b>Princess Anne Somerset Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Everett Sutter</b> EXAMINER'S NAME (Type) <b>Everett Sutter MD</b>		22. DATE SIGNED <b>12-27-67</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Somerset Co.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-28-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mt Carmel</b>		23d. LOCATION (City, town or county) (State) <b>Princess Anne, Md.</b>	
24. FUNERAL DIRECTOR <b>William H James Jr, Princess Anne</b> ADDRESS		25a. REC'D BY REGISTRAR <b>DEC 29 1967</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**CERTIFICATE OF DEATH**

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1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b <b>6 Days</b>			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>McCready Memorial Hospital</b>				d. STREET ADDRESS <b>216 Myrtle Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Beulah</b> Middle <b>E</b> Last <b>Moore</b>				4. DATE OF DEATH Month <b>Dec.</b> Day <b>5</b> Year <b>1967</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1885 Dec. 21, 1887</b>		9. AGE (In years lost birthday) <b>81 yrs.</b>	10. IF UNDER 1 YEAR Months <b>8</b> Days <b>1</b> Hours <b>1</b> Min.	11. IF UNDER 24 HRS. Hours <b>1</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retail Stores</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Crisfield, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Algie T. Moore</b>				14. MOTHER'S MAIDEN NAME <b>Rebecca F. Allen</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-05-4610</b>		17. INFORMANT Address <b>Miss Elizabeth Mackey, same as 2 abcd</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic Failure</b> <b>1561</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of Liver</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis (generalized)</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov 1</b> , 19 <b>67</b> , to <b>Dec 5</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>12/5/67</b> , 19 <b>67</b> , and that death occurred at <b>5:30 M.</b> from causes and on the date stated above.							
22a. SIGNATURE <b>S. M. Peyton</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>S. M. Peyton, M.D.</b>				22d. ADDRESS <b>Main St. Crisfield, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec. 7, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Crisfield Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Crisfield, Md.</b>	
24. FUNERAL DIRECTOR <b>Bradshaw &amp; Sons -- Crisfield, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>DEC 7, 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

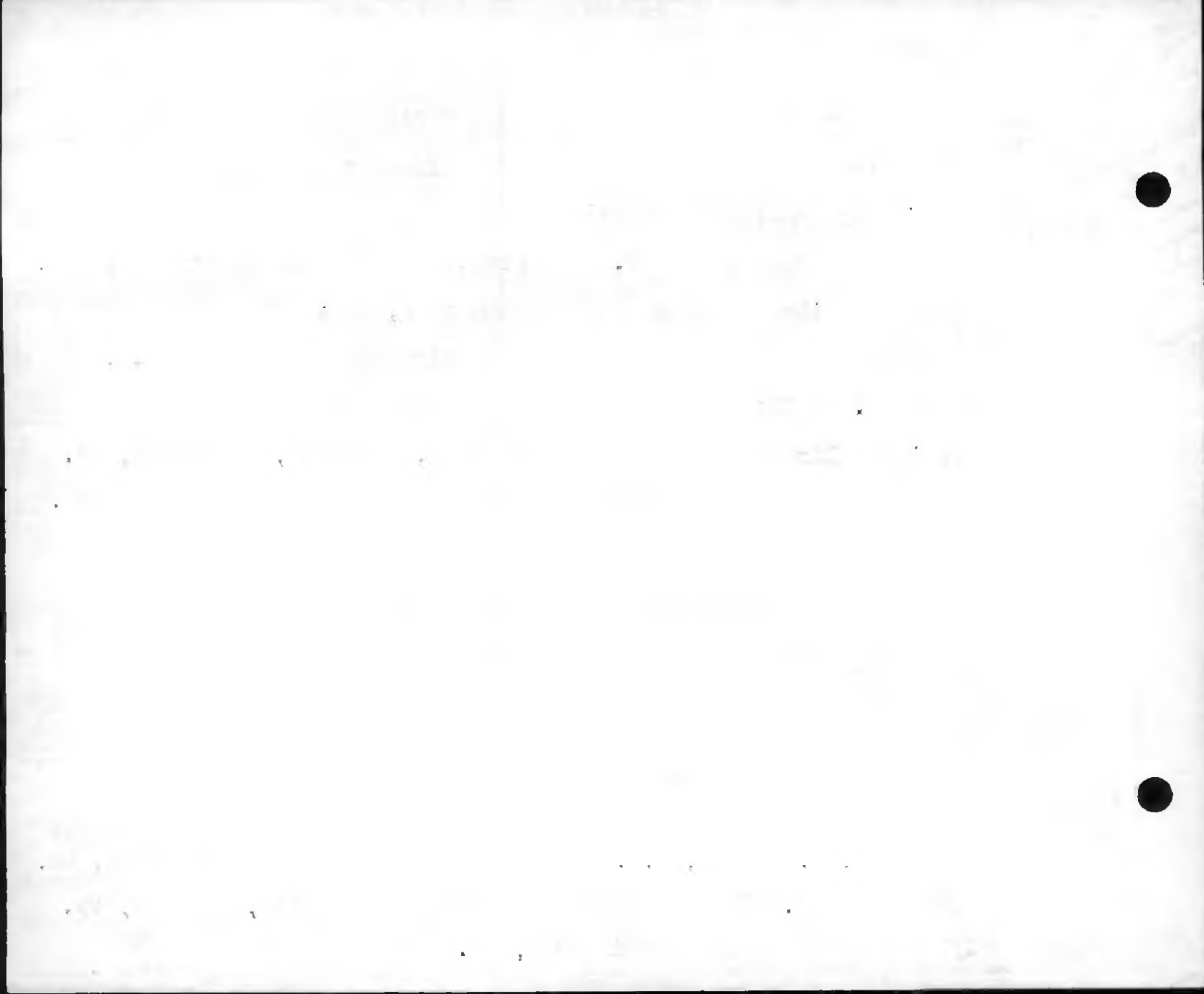
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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Accomac</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>		c. LENGTH OF STAY IN 1b <b>Tangier</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>McCreedy Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>T.</b> Last <b>Pruitt</b>		4. DATE OF DEATH Month <b>December</b> Day <b>20</b> Year <b>1967</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 3, 1895</b>
9. AGE (In years, months, and days) <b>72</b> yrs.		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>22</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waterman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Virginia</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Steven E. Pruitt</b>		14. MOTHER'S MAIDEN NAME <b>Evelyn Evans</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>War 1 and War 2</b>		16. SOCIAL SECURITY NO. <b>Edward G. Crockett, Crisfield, Md.</b>	
17. INFORMANT <b>Edward G. Crockett, Crisfield, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>465X</b> IMMEDIATE CAUSE (a) <b>Pulmonary embolism</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>C. G. Rawley</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>C. G. Rawley, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <b>12/22/67</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) <b>Crisfield, Md.</b>		23. LOCATION (City or town) (County) (State) <b>Tangier, Accomac, Va.</b>	
23a. BURIAL, CREMATION, or other disposition (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12.23/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Family Cemetery</b>		23d. LOCATION (City or town) (County) (State) <b>Crisfield, Md.</b>	
24. FUNERAL DIRECTOR <b>James Herman</b>		25a. REC'D BY REGISTRAR <b>DEC 27 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>James Herman</b>		25c. REGISTRAR'S SIGNATURE <b>James Herman</b>	



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 18b film # 496 1-2-63 mt Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item #6 Film # 396 12/29/67 km <b>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</b>											
1 PLACE OF DEATH a COUNTY <b>SOMERSET</b> MARYLAND b CITY OR TOWN (If outside corporate limits write RJRAL and give nearest town) <b>CRISFIELD</b> c LENGTH OF STAY IN 1b <b>LIFE</b>						2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MD</b> b COUNTY <b>SOMERSET</b> c CITY OR TOWN (If outside corporate limits, write RJRAL and give nearest town) <b>CRISFIELD</b> d STREET ADDRESS <b>115 S. 4TH ST.</b> e RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3 NAME OF DECEASED (Type or print) First Middle Last <b>PRESTON Scarborough</b>						4 DATE OF DEATH Month Day Year <b>12 13 1967</b>					
5 SEX <b>Male</b>		6 COLOR OR RACE <b>Negro</b>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <b>DEC. 10, 1895</b>		9 AGE (in years last birthday) <b>72</b> yrs		10 UNDER 1 YEAR Months Days Hours Min 11 UNDER 24 HRS	
10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>LABORER</b>				10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) <b>CRISFIELD MD.</b>				12 CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13 FATHER'S NAME <b>Richard Scarborough</b>						14 MOTHER'S MAIDEN NAME <b>Ruth Jackson</b>					
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16 SOCIAL SECURITY NO <b>217-148200A</b>		17 INFORMANT <b>George Scarborough (Crisfield)</b>				Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>NATURAL CAUSES</b> 4701 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <b>Acute Myocardial Infarction</b> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <b>2 WEEKS</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c TIME OF INJURY Month, Day, Year Hour am pm <b>19</b>				20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.)		20f (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>A. N. BARR, M.D.</b> EXAMINER'S NAME (Type) <b>A. N. BARR</b>						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)					
22. DATE SIGNED <b>12/18/67</b>											
23a BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b DATE THEREOF <b>12/16/67</b>		23c NAME OF CEMETERY, OR CREMATORY <b>Asbury</b>		23d LOCATION (City or town) (County) (State) <b>CRISFIELD MD.</b>			
24 FUNERAL DIRECTOR <b>Anthony E. Ward Crisfield MD</b>						25a REC'D BY REGISTRAR <b>DEC 26 1967</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

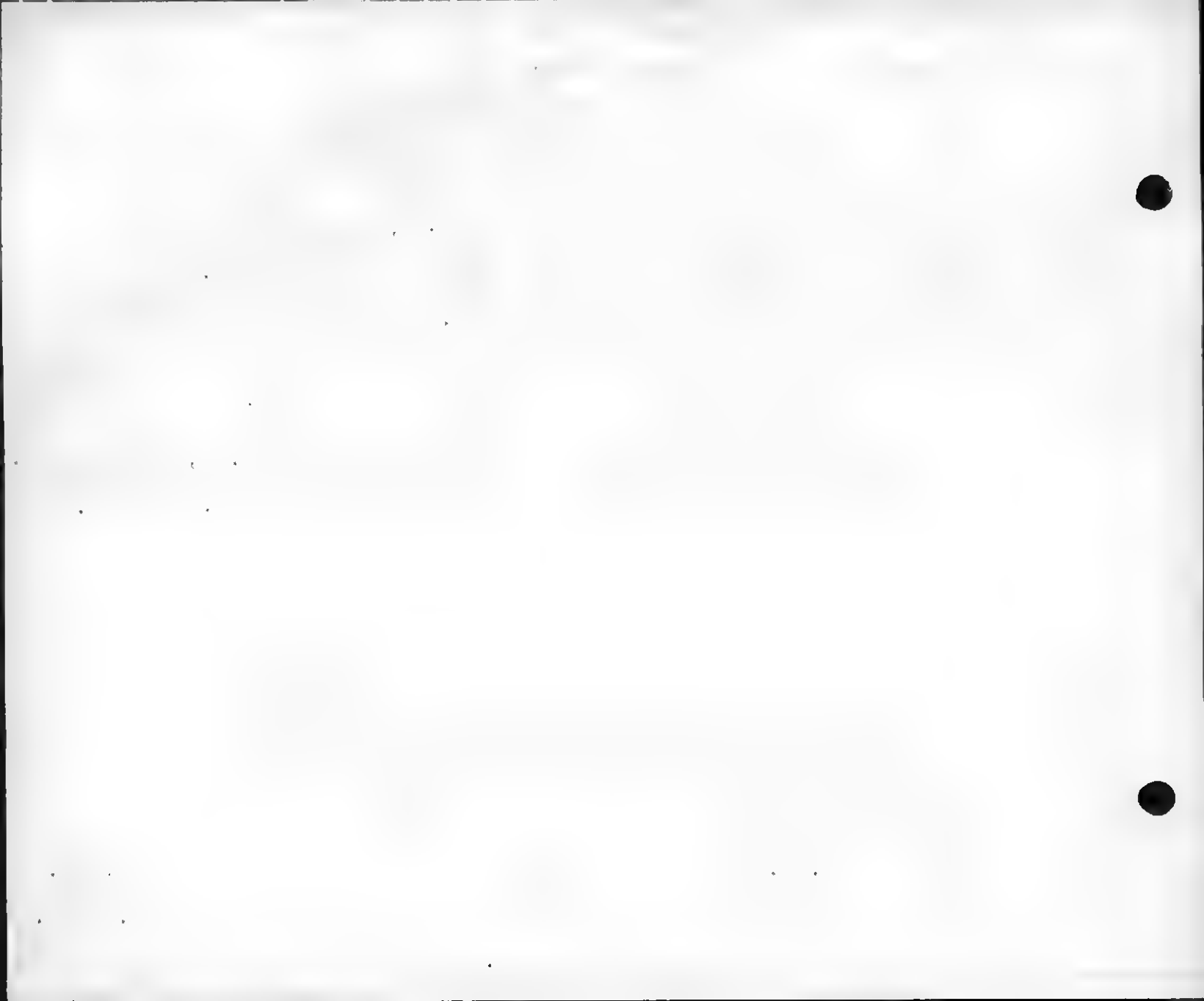
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1664

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(Rural) Crisfield</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(Rural) Crisfield</b>	
c. LENGTH OF STAY IN b. <b>Lifetime</b>		d. STREET ADDRESS <b>Rt. 1, Lawsonia</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rt. 1, Lawsonia</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>TORRENCE</b> First Middle Last		4. DATE OF DEATH <b>Dec. 9 19 67</b> Month Day Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 30, 1967</b>
9. AGE (in years last birthday) <b>2</b> yrs		10. F UNDER 1 YEAR <b>2</b> Months <b>9</b> Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Lucille Sterling</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO <b>None</b>	
17. INFORMANT <b>Lucille Sterling, Rt. 1, Crisfield, Md.</b> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Crib death (Viral pneumonitis, acute.)</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>DUE TO</b> (c) <b>DUE TO</b>			INTERVAL BETWEEN ONSET AND DEATH <b>hrs.</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>C. G. Rawley</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>C. G. Rawley</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <b>Crisfield, Md.</b>	
22. DATE SIGNED <b>12/12/67</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12/12/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Asbury Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Crisfield Som. Md.</b>
24. FUNERAL DIRECTOR <b>Anthony E. Ward</b> ADDRESS <b>Crisfield, Md.</b>		25a. REC'D BY REGISTRAR <b>DEC 20 1967</b> DATE	
		25b. REGISTRAR'S SIGNATURE <b>Charles J. [Signature]</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

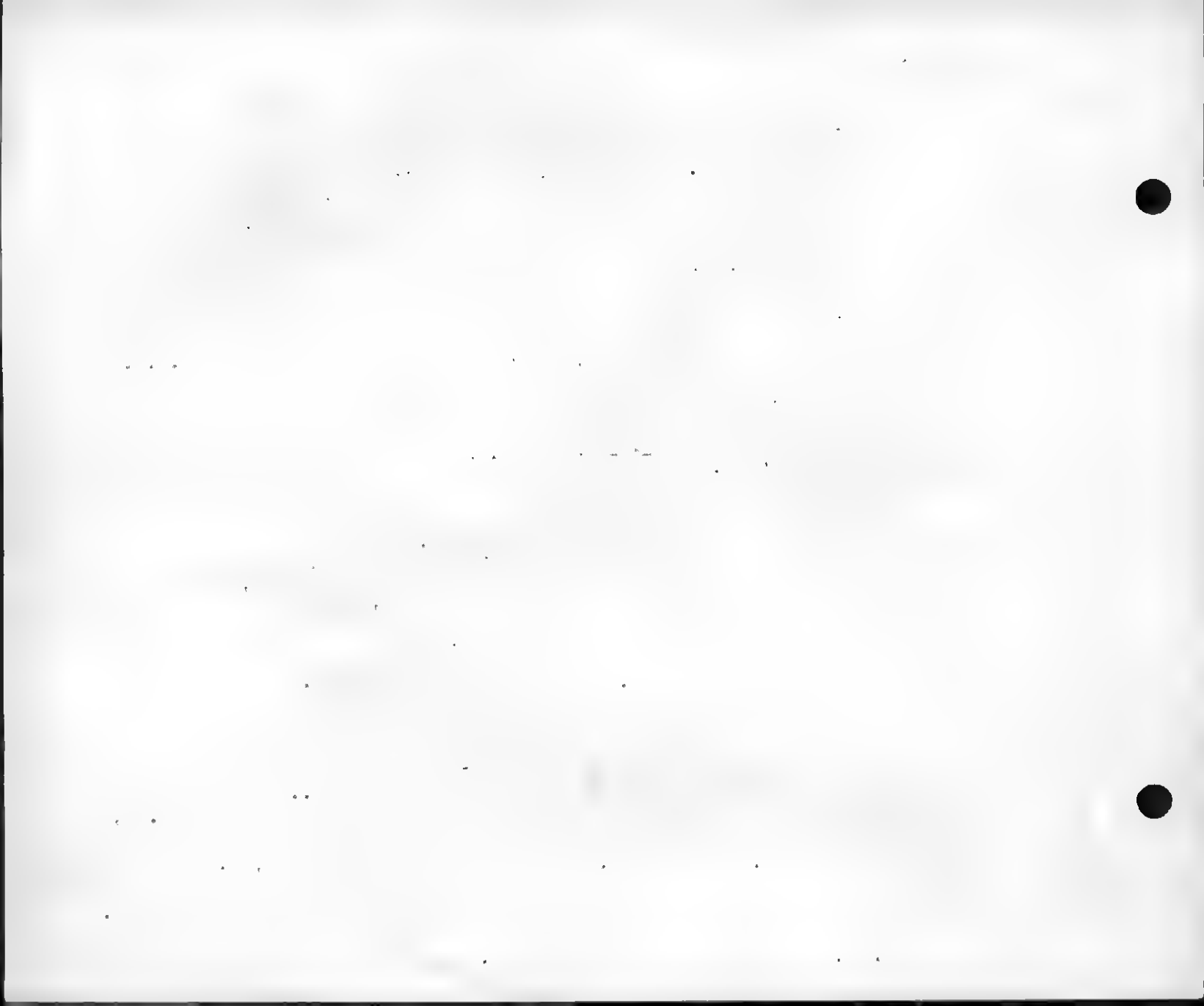
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

665

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ewell, Smith I.</b>				c. LENGTH OF STAY IN 1b <b>20 years</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <b>P.O. Box 66</b>			
3. NAME OF DECEASED (Type or print) First <b>BURLEIGH</b> Middle <b>HAROLD</b> Last <b>TAYLOR</b>				4. DATE OF DEATH Month <b>December</b> Day <b>15</b> Year <b>19 67</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 21, 1896</b>	9. AGE (In years lost birthday) <b>71</b> yrs	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS. Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Building &amp; Repairs</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Guilford, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry Thomas Taylor</b>				14. MOTHER'S MAIDEN NAME <b>unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES (1918 WWI WWI I)</b>		16. SOCIAL SECURITY NO <b>230-18-0982</b>		17. INFORMANT Address <b>Mrs. Winnie Taylor, same as 2 abcd</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Coronary Artery Disease, severe</b> DUE TO <del>*****</del> <b>moderately severe</b> (c) <b>Cardio-vascular-renal Disease</b> <del>*****</del> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Upper respiratory disease, moderately severe</b>						INTERVAL BETWEEN ONSET AND DEATH <b>One hour</b> <b>Ten Years</b> <b>15 Years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>No Accident. Patient died in his sleep.</b>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>None</b> p.m. <b>19</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work or While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>None</b>		20f. (City or town) (County) (State) <b>No accident</b>	
21. I certify that (I) ( <del>He</del> ) attended the deceased from <b>July</b> , 19 <b>62</b> , to <b>December 15, 1967</b> , that (I) ( <del>He</del> ) last saw the deceased alive on <b>December 14, 1967</b> , and that death occurred at <b>1:30 P.M.</b> from causes and on the date stated above.							
22a. SIGNATURE <b>Thomas C. Gentry, M.D.</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Dec. 17, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Thomas C. Gentry, M.D.</b>				22d. ADDRESS <b>Ewell, Maryland, P.O. Box 11 21824</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec. 19, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ewell Methodist Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Ewell, Somerset, Md.</b>	
24. FUNERAL DIRECTOR <b>Levin R. Wilson - Somerset County, Md.</b>				25a. REC'D BY REGISTRAR <b>DEC 21 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Johnas Judge</b>	

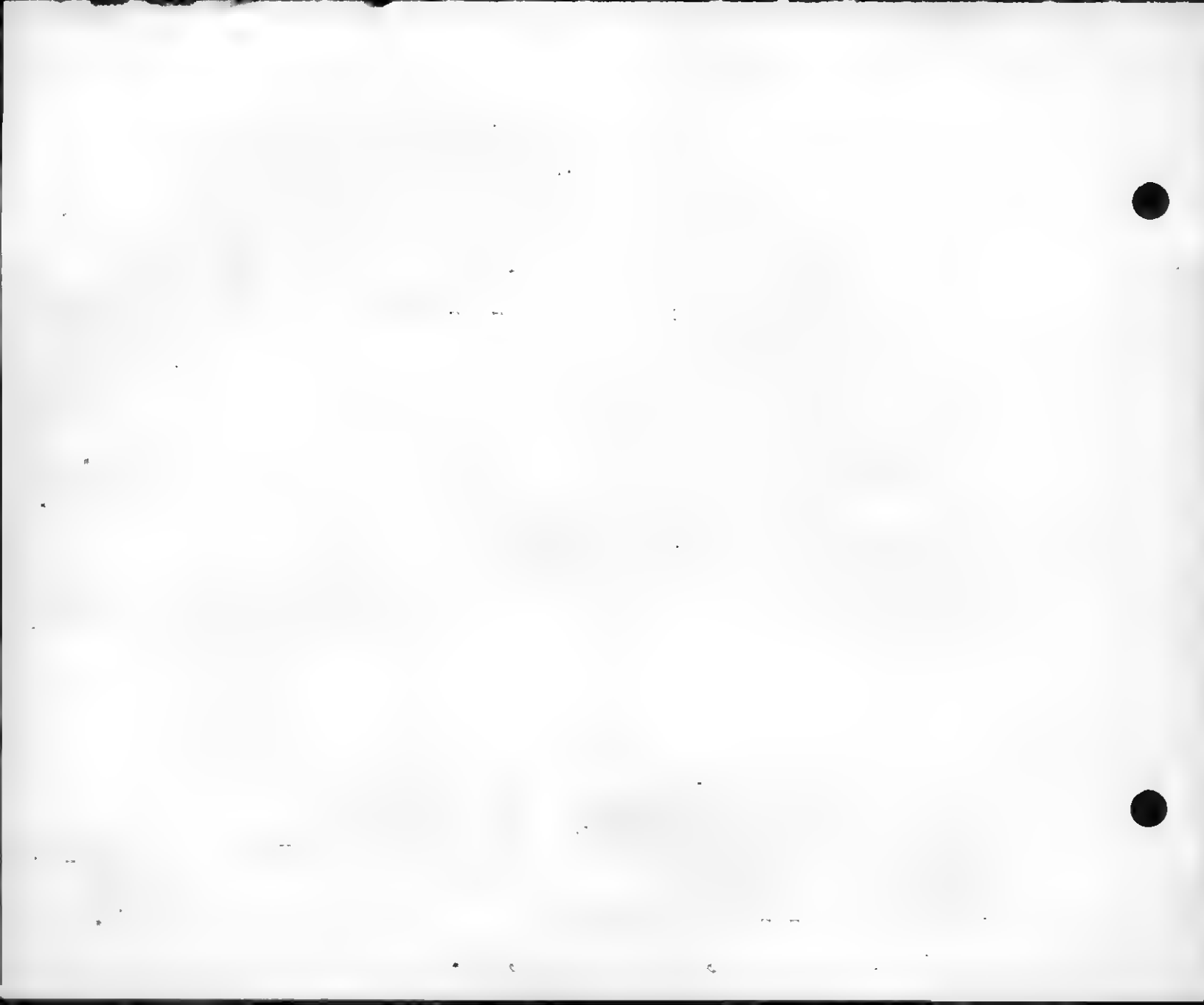


TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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FOR STATE HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
Item 8 Film G396 12-19-67											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Somerset</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Princess Anne</u> c. LENGTH OF STAY IN 1b <u>Life time</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Princess Anne</u> d. STREET ADDRESS  e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>Tilghman</u> Middle <u>Tilghman</u> Last			4. DATE OF DEATH Month <u>12</u> Day <u>2</u> Year <u>19 67</u>								
5. SEX <u>male</u>		6. COLOR OR RACE <u>color</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1877</u> <u>1-15-1878</u>		9. AGE (in years last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>John Tilghman Sr</u>					14. MOTHER'S MAIDEN NAME <u>Eliza Maddox</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Lilla Barkley, Princess Anne, Md.</u> Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u>  <u>years</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Everett Sutter MD</u> EXAMINER'S NAME (Type)				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22. DATE SIGNED <u>Some sot 12-6-67</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>12-7-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>John Wesley</u>		23d. LOCATION (City, town or county) (State) <u>Princess Anne Md.</u>			
24. FUNERAL DIRECTOR <u>William H James Jr, Princess Anne, Md.</u> ADDRESS						25a. REC'D BY REGISTRAR <u>DEC 11 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Chamley Judge</u>			



MARYLAND STATE DEPARTMENT OF HEALTH

12662 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17667

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(Rural) Princess Anne</b>		c. LENGTH OF STAY IN 1b <b>4 years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <b>LOVE</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>23</b> Year <b>19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 4, 1928</b>
9. AGE (In years last birthday) <b>39</b> yrs.		10. IF UNDER 1 YEAR Months <b>3</b> Days <b>23</b> Hours <b>19</b> Min <b>67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm work</b>	
11. BIRTHPLACE (State or foreign country) <b>Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>220-52-7802</b>	
17. INFORMANT <b>Willie Rogers</b>		Address <b>Princess Anne, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>3222</b> IMMEDIATE CAUSE (a) <b>Alcoholism</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE <b>C. G. Rawley</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>C. G. Rawley, M. D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <b>Crisfield, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12/28/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>House of Jacob Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Chance Somerset Md.</b>
24. FUNERAL DIRECTOR <b>William H. James, Jr. Princess Anne, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>12/29/67</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-5. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Dames Quarter</b> c. LENGTH OF STAY IN life <b>life</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Dames Quarter</b> d. STREET ADDRESS <b>19-1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <b>Oscar Wilson</b>		4. DATE OF DEATH Month Day Year <b>Dec 4 1967</b>					
5. SEX <b>male</b>	6. COLOR OF RACE <b>col</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-18-1888</b>	9. AGE (in years last birthday) <b>79 yrs.</b>	10. IF UNDER 1 YEAR Months Days Hours Min.	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY		13. FATHER'S NAME <b>Frank Wilson</b>		14. MOTHER'S MAIDEN NAME <b>Mary Wesley</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>W-I</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Major Wilson, Dames Quarter, Md</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxiation</b> <b>9/60</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>house burned down</b>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>10 p.m. 12-4-67</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Dames Quarter Somerset Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Everett Sutter</b>		EXAMINER'S NAME (Type) <b>Everett Sutter MD</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED <b>Somerset 12-6-7</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-10-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Macedonia</b>		23d. LOCATION (City, town or county) (State) <b>Dames Quarter, Md.</b>	
24. FUNERAL DIRECTOR <b>William H James Jr, Princess Anne, Md</b>				25a. REC'D BY REGISTRAR <b>DEC 11 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

